

# CLINICAL ATTACHMENT AUSTRALIA & INTERNATIONAL ENROLMENT FORM



## Personal details

Name (for certificate):		
Medical practice name:		
Postal address:		
Phone:	Fax:	Email:
Member of: <input type="checkbox"/> RACGP <input type="checkbox"/> ACRRM <input type="checkbox"/> RNZCGP <input type="checkbox"/> Other:	CPD number:	
How did you hear about us?		

## Program selection

<b>Skin Cancer:</b>	<input type="checkbox"/> Redcliffe Skin Cancer Centre Queensland, Australia	<input type="checkbox"/> Monash Skin Cancer Centre Victoria, Australia
	<input type="checkbox"/> Medical University of Vienna Vienna, Austria	<input type="checkbox"/> Medical University of Lyon Lyon, France
<b>Dermatology:</b>	<input type="checkbox"/> Medical University of Vienna Vienna, Austria	
<b>Aesthetic Medicine:</b>	<input type="checkbox"/> Southern Cosmetics Clinic Melbourne, Victoria, Australia	<input type="checkbox"/> Haly Health & Skin Medical Kingaroy, Queensland, Australia
	<input type="checkbox"/> The Academy of Aesthetic Regenerative Medicine London, United Kingdom	
<b>Clinical Attachment GP fee: (Australia)</b>	<b>Clinical Attachment nurse fee: (Australia - skin cancer only)</b>	<b>Clinical Attachment GP fee: (international)</b>
<input type="checkbox"/> 2 DAY PROGRAM: <b>\$1995.00</b>	<input type="checkbox"/> 2 DAY PROGRAM: <b>\$1500.00</b>	<input type="checkbox"/> 2 DAY PROGRAM: <b>\$2995.00</b>
<input type="checkbox"/> 5 DAY PROGRAM: <b>\$3495.00</b>	<input type="checkbox"/> 5 DAY PROGRAM: <b>\$2995.00</b>	<input type="checkbox"/> 5 DAY PROGRAM: <b>\$4995.00</b>
<b>Preferred attendance date:</b> Please provide your three preferred dates in order of preference (e.g. 12-16 June or w/c 12 June).		
Date 1: _____	Date 2: _____	Date 3: _____

## Payment method

Payment for the Clinical Attachments is required 30 days in advance. Please select your preferred payment method below.	
Direct deposit:	Account name: SCI OPERATIONS. BSB: 064-445. Account Number: 1041-0752. REF: Invoice number or surname as enrolled.
Credit card:	<input type="checkbox"/> Master Card <input type="checkbox"/> VISA <input type="checkbox"/> American Express
Name on card:	
Card number:	
Exp: MONTH / YEAR	CVC:
Signature:	

Please return the completed form by fax to 07 3319 6251 or email to [admin@healthcert.com](mailto:admin@healthcert.com)